Washington State Department of Health

Neurologic Syndrome

Disease:

LHJ Use ID _____
LHJ Classification ☐ Confirmed ☐ Probable
By: ☐ Lab ☐ Clinical ☐ Other: _____
Outbreak # (LHJ) _____ **(DOH)** _____
County

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation start date: ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	Fever Highest measured temp: _____ °F Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk
☐	☐	☐	☐	Headache
☐	☐	☐	☐	Nausea
☐	☐	☐	☐	Vomiting
☐	☐	☐	☐	Muscle aches
☐	☐	☐	☐	Stiff neck
☐	☐	☐	☐	Seizures new with disease
☐	☐	☐	☐	Confusion
☐	☐	☐	☐	Tremors or hand shakes
☐	☐	☐	☐	Weakness
☐	☐	☐	☐	Eyes sensitive to light (photophobia)

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	Abnormal neurologic findings
☐	☐	☐	☐	Altered mental status
☐	☐	☐	☐	Psychiatric diagnosis
☐	☐	☐	☐	Cranial nerve abnormalities (e.g., bulbar weakness, diplopia, dysphagia)
☐	☐	☐	☐	Movement disorder
☐	☐	☐	☐	Ataxia
☐	☐	☐	☐	Paralysis or weakness

☐ Acute flaccid paralysis ☐ Asymmetric
☐ Symmetric ☐ Ascending ☐ Descending

Clinical Findings (cont'd)

Y	N	DK	NA	
☐	☐	☐	☐	Rash observed by health care provider
☐	☐	☐	☐	Guillain-Barrŕe syndrome
☐	☐	☐	☐	Meningitis
☐	☐	☐	☐	Encephalitis or encephalomyelitis
☐	☐	☐	☐	Coma
☐	☐	☐	☐	Complications, specify: _____
☐	☐	☐	☐	Admitted to intensive care unit

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy Place of death _____

Laboratory

P = Positive O = Other, unknown
N = Negative NT = Not Tested
I = Indeterminate

Specimen type _____ Specimen type _____
Collection date ___/___/___ Collection date ___/___/___

P	N	I	O	NT	
☐	☐	☐	☐	☐	CSF obtained

Profile: wbc ____ (% lymph_____ % neutr____)
rbc ____ prot ____ gluc ____

NOTES

Answers are: Yes, No, Unknown to case, Not asked /Not answered

Case Name: _____

EXPOSURES

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____
_____
_____

☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____

☐ ☐ ☐ ☐ Case knows anyone with similar symptoms

☐ ☐ ☐ ☐ Recent head trauma Date: ___/___/___

☐ ☐ ☐ ☐ Dietary supplements/alternative medicine
Specify: _____

☐ ☐ ☐ ☐ Recent medication change (new med./dosage change) Specify: _____

Y N DK NA

☐ ☐ ☐ ☐ Recent illness
☐ Resp. ☐ GI ☐ Other: _____

☐ ☐ ☐ ☐ Recent vaccination Specify: _____

☐ ☐ ☐ ☐ History of animal bite Date: ___/___/___
Type of animal: _____

☐ ☐ ☐ ☐ Insect or tick bite
☐ Deer fly ☐ Flea ☐ Mosquito ☐ Tick
☐ Louse ☐ Other: _____ ☐ Unk
Location of insect or tick exposure
☐ WA county ☐ Other state ☐ Other country
☐ Multiple exposures ☐ Unk
Date of exposure: ___/___/___

☐ ☐ ☐ ☐ Employed in laboratory

☐ ☐ ☐ ☐ Organ or tissue transplant recipient
Date of receipt:__/__/__

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES	PUBLIC HEALTH ACTIONS

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____ **Record complete date** ___/___/___